Learning from Each Other: Identifying Further Needs for Older Adult Programming at Four Canadian Mental Health Association Regional Branches from the Perspectives of Front Line Staff

by

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Acronyms and Symbols

CMHA	Canadian Mental Health Association
CMHA-VF	Canadian Mental Health Association Vancouver Fraser

Abstract

The purpose of this project is to review existing programs that are available to the older adult population aged 55 and over with Mental Health issues at four BC Canadian Mental Health Association (CMHA) branches, with a focus on service providers' perceptions of program opportunities. The selected branches include Vancouver-Fraser (CMHA-VF) branch, North and West Vancouver, Shuswap-Revelstoke, and Kelowna branches. The reason for conducting research on this topic is to determine what types of targeted programming might best support regional older adults with mental health concerns. Data was collected using FluidSurveys, and the survey questions allowed for both qualitative and quantitative data. The questions encouraged participants to share their views as front-line staff who work with clients, and what they determine to be effective programs for older adults versus in their view, and what they believe their agency may be able to benefit from, for future programming. Five thematic categories were developed from participants' feedback: stigma, education and outreach, leisure/recreational/social wellness programs, how to access resources and future older adult programming. These themes demonstrate not only the work front-line staff members are currently doing within the agency, but also areas of program development that are identified. A theoretical framework of Erik Erikson's life span development perspective, and exploring the various social determinants of health, provides a foundation for understanding why older adults experience social exclusion and are denied the opportunity to gain access to resources.

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Introduction

The purpose of this project is to review existing programs that are available to the older adult population with Mental Health issues at four BC Canadian Mental Health Association (CMHA) branches, with a focus on service providers' perceptions of program opportunities. This study provides CMHA as an agency, as well as each branch, an opportunity to learn from each other about specific programs, and how we can improve our programming. The selected branches include Vancouver-Fraser (CMHA-VF) branch CMHA North and West Vancouver, Shuswap-Revelstoke, and Kelowna branches. The older adult population for the purpose of this study comprise those aged 55 years and over. This study does not delve into illnesses and diagnoses, instead focusing on the needs of the population based on a survey of the service providers' perspectives. The reason for conducting research on this topic is to determine what types of targeted programming might best support regional adults who are aged 55 and over with mental health concerns.

I currently work in a unique partnership with a Vancouver Coastal Health community mental health team; and the Vancouver Fraser CMHA branch. I have been employed as a Vocational Rehabilitation Counselor with them since July 2013. The agency has a wide range of programming for individuals of all ages. However, it unfortunately does not currently offer specific programming for older adults. Being part of CMHA-VF, and working primarily with the adult population on a community mental health team, my interest to further research programming for the older adult population was sparked by the voices of older adults who expressed how they would like to participate in groups with people their own age - to be around individuals they could relate to and feel included in social settings. Research is required to

assess the level of programming that is currently available to the older adult population and what programs can be considered or further explored for future implementation.

Diversity in CMHA Branches

The CMHA branches differ from each other in some ways. Demographically, Shuswap-Revelstoke is the smallest branch comprising of thirteen staff members. Their Executive Director advised me that they provide services to many seniors, but they also do not have a specific seniors program. However, Kelowna, North and West Vancouver and Vancouver Fraser branches are larger branches; they serve many individuals of all ages with mental health concerns in cities where the population continues to grow and expand. Similarly, when considering the demographics of the various communities including their ethnic and cultural make up, as well as other languages, socio-economics and whether these branches support programming for First Nations communities, further potential gaps are evident. For example, Vancouver Fraser branch acknowledges the Chinese community. The Chinese Mental Health Promotion Program increases the awareness of mental health issues and promotes wellness in the community through recreational and leisure activities while reducing stigma associated to mental illnesses. Also, Vancouver Fraser, Shuswap Revelstoke and North and West Vancouver branches offer telephone coaching in English, French, Cantonese and Punjabi. Incorporating different languages and offering programs to serve different communities (including older adults) can only strengthen the organizations as a whole.

Older Adults and Risk Factors

Cornwell, Laumann, and Schumm, 2008 (as cited in Sibley, Thompson, and Edwardh, 2016), explain that old age is described as a transitional period where older adults encounter

changes in both their physical health, as well as social roles (e.g., retirement, children becoming adults); these transitional changes are significant because older adults who adjust to later life transitions by being socially active tend to live a happier and healthier life than those who do not (p. 1).

According to the Statistic Canada, the senior population aged 65 and older has been increasing. In a 2016 Census report, the total number of older adults age 65 years and over were 5,935,630. Additionally, in that same year 16.9 percent of the population was age 65 years and over. Growth in the senior population is larger than that of the child population in Canada. The Statistics Canada 2015 annual demographic estimates report indicates that Canada had an increasing number of older adults age 65 and over than individuals age 0 to 14. It is also estimated that the proportion of the population age 65 and over may increase by 20 percent in the year 2024 and 25 percent in 2025 (p. 51). Demographic projections indicate that this population is expected to increase rapidly until the year 2031 when all of the baby boomers will have reached the age 65. The report also indicates that seniors could represent 23 percent to 25 percent of the total population by the year 2036 (p. 406).

Further, Donnelly (2002) indicates that "the number of seniors is rising dramatically in BC, Canada and the world as a whole" (p. 4). Her review and analysis of seniors' health in BC identifies some of the associated potential risk factors. Donnelly (2002) asserts that "the over 85s in Canada are growing four times faster than younger segments of the population" (p. 4); specifically, due to living healthier lifestyles.

However, from a social determinant of health perspective, seniors are vulnerable to various risk factors, and as explained by Donnelly (2002), some seniors are susceptible to more serious and challenging problems with older age. "Some seniors come to older age with chronic

mental illnesses including schizophrenia, bipolar disorders, substance abuse, or recurrent depressions, but most seniors' mental health problems arise in old age. These problems range from anxiety, mood disorders and substance abuse, to delirium (acute confusion) and dementia" (p. 4). Aside from enduring mental illnesses, older adults are also vulnerable to other social determinants such as loneliness and social isolation which impacts their overall health. For example, research indicates that older adults are at risk of loneliness as they age; specifically, when partners separate (divorce) or those who have never been married are aging, when a partner passes away, or when other support networks live elsewhere and require long travel. Other risk factors amongst the older adult population include deprived living conditions and a lack of social networks and/or social engagement. Loneliness and isolation can be connected to one's socioeconomic status and its influence on one's ability to diversify their social networks, as well as their educational level and its association to status and the social networks around employment. The research reflects the importance of building social networks and supports around oneself to alleviating feelings and experiencing loneliness (de Jong Gierveld, Keating and Fast, 2015, p. 127-128).

Social Determinants of Health and Life Span Development Perspective

By learning about the views of front line staff who are able to recognize some of these risk factors and challenges presented to older adults, the hope is for the CMHA-VF branch to move forward in acknowledging the gaps in services and provide an opportunity for branches to learn from each other.

A focus on the natural life span development perspective provides a basis for a theoretical framework in which areas for growth in older adult programming are identified. This project also examines the link between mental health concerns in older adults and its connection to

various social determinants of health. Additionally, this project provides a foundation for further exploration, to foster curious learning and to strengthen the research regarding mental health programming for the older adult population.

Literature Review

This literature review will cover research pertaining the mental health programming needs of older adults, from a social determinant of health approach. In order to provide necessary context for the findings in this research study, the literature review also describes existing CMHA programs that may target social determinant issues. Many sources of literature including online published articles were searched by using the University of the Fraser Valley's online library database, as well as published literature which was accessed directly from the Canadian Mental Health Association websites. Several search terms were used when attempting to find appropriate literature online. These included: older adults, mental health, older adults and programs, older adults and stigma, older adults in Canada and older adults and the Canadian Mental Health Association. This section reviews literature pertaining to the stigmatization of older adults with mental health concerns, the social determinants of health and older adult mental health, and CMHA programs. Gaps in the literature are also identified.

The Stigmatization of Older Adults Due to Having Mental Health Concerns

Mental health and illness often projects stigma on the individual not only detrimental to one's personal health and well-being, but also creates fear of being labeled and thus oppressing the individual based on those labels. Meier, Csiernik, Warner and Forchuk (2015) address two forms of mental illness stigma: public or social stigma and self or internalized stigma. Public stigma is the negative prejudicial attitudes that are held by society towards individuals with mental illnesses. Internalized stigma is a result of applying those negative stereotypes held by

the public in society to oneself. Believing in those thoughts can often result in personal shame, withdrawal and loss of self-esteem (p. 213). Additionally, Meier, Csiernik, Warner and Forchuk (2015) discuss The Stigma Scale; a tool which is "a standardized measure of the stigma of mental illness" (p. 214). The purpose of this study is to review the experiences of those individuals who experience stigma and how it affects their lives. The Stigma Scale is a standardized measure of the stigma of mental illness where the purpose of the scale is to examine the experiences of those individuals living with mental illnesses (p. 214-215). The study took place in London, Ontario, Canada and a total of 380 psychiatric survivors participated in the study. Individuals were recruited to participate if they had been diagnosed with a mental illness for a minimum of one year prior to participation (p. 215). Based on their findings, stigma continues to promote negative stereotypes and continues to "disenfranchise and marginalize groups who feel talked down to, have faced issues with others because of their mental health problems, and who feel their chances in life have been limited by mental illness" (p. 220). Additional literature by Hehman and Bugental (2013) provide insight from a study that was conducted to investigate an individual's perceptions and biases in response to stigma that one experiences at various ages. The study also explains the consistent stigmatization and negative perception of older adults as incompetent and experiencing a decline in their cognitive abilities. Also, the study presents a life stage specific model that highlights "there is evidence that suggests older adults respond to age-based stigma in a way that is consistent with stereotype threat (i.e., performance deficit that confirms stereotype); such as being unable to complete a task that requires agility and speed in comparison to a youth who may be able to complete those tasks successfully (p. 1399). Additionally, Widrick and Raskin (2010) provide insight into attaching stigma and creating a negative identity for older adults. They explain that stigma is

attached when people display attributes that conflict with societal values, resulting in broader assumptions, stereotypes and affecting one's mental health. These stereotypes influence people's thoughts resulting in an ongoing cycle of negativity, assumptions and influencing ageist ideology. The interconnections of older age and older adults being perceived as incompetent and through many misguided perceptions about mental illnesses demonstrate the disconnect with society's assumptions versus acknowledging the individuals lived experiences.

Social Determinants of Health

Social determinants of health are factors that exclude marginalized populations from achieving appropriate living conditions and deter the vulnerable from equal access to resources; including resources offered in the community such as ones at CMHA. Raphael (2009) in his research describes social determinants of health as "the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole" (p. 2). The social determinants of health, as explained by Mikkonen and Raphael (2010), are the living conditions that individuals experience rather than medical treatments or lifestyle choices that individuals make. The authors explain that the importance to health of such living conditions was developed in the mid-1800s and has been a part of the Canadian government policy documents since the mid-1970s (p. 7). The World Health Organization has identified these social determinants of health, and according to Bryant, Raphael, Schrecker and Labonte (2011), it is "the next frontier for reducing health inequalities" (p. 44).

From a Canadian perspective, based on a conference which was organized by Raphael out of York University in Canada, and as described in his research (2009), twelve social determinants of health were identified. The purpose of this conference was to address several factors that proved to be concerning in regards to public policy and how the general population

was often misinformed concerning various social determinants of health in Canada. Instead of strengthening to support Canadians with a balanced quality of health and care, policies were instead designed to oppress and weaken the quality of many social determinants of health. Three factors were identified from the conference: (1) consider the state of several key social determinants of health across Canada; (2) explore the implications of these conditions for the health of Canadians; and (3) outline policy directions to strengthen these social determinants of health (p. 7). Additionally, as a result of the conference, Raphael (2009) identified the following twelve social determinants of health: Aboriginal status, early life, education, employment and working conditions, food security, gender, health care services, housing, income and its distribution, social safety net, social exclusion and unemployment and employment security. These are some of the specific determinants that help to understand the social and societal inequalities that exist which prevent individuals from obtaining equal access to resources, experiencing poor living conditions as well as adverse health concerns.

The social determinants of health have not only influenced health care in Canada, but social work as well. Increasing inequalities lead to barriers for marginalized populations. The role of social work in Canada becomes imperative in recognizing these systemic barriers and strengthen their practice towards advocating for equal and fair access to resources. Not only is advocacy required, but public support and recognition of the gaps in services is also important to acknowledge. Inequalities and barriers often lead to social exclusion. Raphael (2009) asserts that "social exclusion refers to specific groups being denied the opportunity to participate in Canadian life. In Canada, Aboriginal Canadians, Canadians of colour, recent immigrants, women, and people with disabilities are especially likely to experience social exclusion" (p. 32). These groups experience increasing disparities and segregation from access to social, cultural

and economic resources. Additionally, these marginalized groups also have little to no power when it comes to influencing decisions made by governments or other institutions that could potentially effect the vulnerable population long-term. Therefore, it is imperative to recognize these social determinants of health and how social work can impact these determinants and act as a voice and advocate to assist those individuals who require it most.

Moreover, there are several social factors to consider regarding the older adult population with mental health concerns. Often, when the older adult population continues to age, they experience many life changing events such as losing a partner or friends due to ailing health and death; losing family connections, inheriting illnesses and experience social isolation. Having community belonging provides the opportunity for older adults to become socially engaged and involved within their communities. Kitchen, Williams and Chowhan (2012) emphasize that "social isolation can adversely affect health while social engagement and attachment can lead to positive health outcomes and significantly reduce mortality risk" (p. 104). Their research explores the link between having a sense of community belonging and the impact on the older adult population's health across both urban and rural communities in Canada. According to the authors, "the research found a significant and consistent association between a sense of belonging and health, particularly mental health, even when controlling for geography and socio-economic status" (p. 103). Their findings also suggest that the smaller, rural communities experienced a greater sense of community belonging, especially found to be highest among seniors, even though there were health deficits attached to the smaller community. Rural, by the authors, was defined as someone who does not live in an urban setting and/or a larger province such as Alberta or Quebec. Several factors were found that contributed to older adults feeling a sense of belonging in their communities. Some of these include: family composition, couples

who were still together, higher household income and those individuals who lived in smaller provinces and rural communities. Unfortunately, the opposite was found for those who did not feel connected to their community, and those individuals included: youth, people living in high rise buildings, individuals from a lower socio-economic status and single parents/unattached individuals (Kitchen, Williams, Chowhan, 2012, p 122). These findings suggest that community connectedness is prevalent in smaller, rural communities due to the size of the population and having the capacity to build strong communities ties; however, it unfortunately does not benefit individuals who have lost family connections, have little to no financial stability, who come from a lower socio-economic household and those individuals who lack social interactions in their lives.

Oelke, Schill, Szostak, Brown, Caxaj, Ardiles, & Larson (2016) discuss the challenges faced by older adults age 50 and above in three rural communities in southern British Columbia. The literature explains that the older adult population is in fact experiencing challenges when trying to access programming. The purpose of the study was to: 1) identify the needs of adults 50 and over experiencing a mental health concern; 2) to identify current services and supports available and gaps in services and supports; and 3) to identify opportunities for integrated services and supports for these individuals, their caregivers and community-based organizations (no page number). Additionally, the researchers used the method of conducting six consultation sessions across three communities with both community members with mental health concerns and organization representatives. In their research, "Six interrelated themes were identified: lack of resources; access issues; poverty; stigma; purpose and meaning in life; and factors influencing mental health" (Oelke et al., 2016, p. 2). Their findings suggest a common concern which was the lack of community-based services and supports, and a further need for services.

Levasseur, Genereux, Bruneau, Vanasse, Chabot, Beaulac and Bedard (2015) identify various social determinants of health that lead to quality of life. They specifically review how neighborhood environments for older adults is associated with their mobility and overall social engagement and participation. The authors recognize that the "older adults make up a sizeable proportion of the population that will, between 2000 and 2050, double from about 11 to 22 %, including almost 400 million people worldwide aged 80 years or older. Many people aged 65 and older suffer from chronic diseases such as arthritis and rheumatism (47.3 %), hypertension (42.8 %), heart disease (19.8 %) or diabetes (13.5 %), and almost half (42 %) have disabilities, which have significant consequences for individuals, communities, and social and health services" (p. 2). For the purpose of their research, the authors define disability as "an impairment in the capacity to perform a physical or mental activity considered normal for a human being" (p. 2). The authors explain that social participation and mobility are key social determinants of successful aging. Their research has found that social participation is a determinant of many favorable health and quality of life outcomes that protect many older adults from cognitive decline (p. 2). The authors also explain that as aging is a natural process, many older adults will see a decline in social participation. However, they also argue that for many, a "lack of neighbourhood resources can restrict social participation and decrease the likelihood of independent living" (p. 2). When accessing resources, it is important to consider transportation and how older adults are expected to travel to community based resources. The authors argue that exclusion of older adults is prevalent where transportation is lacking, and in order to engage older adults into such resources, it is imperative to provide the basic means of transportation and accessibility in order for older adults to attend activities. As noted by the authors, "integrating older adults into their community can provide them with emotional support, motivation,

information, social interaction, friendship and sense of belonging" (p. 13). This is specifically the case for the less advantaged older adults and their communities, therefore, acknowledging the need for accessibility is required.

Moreover, Anderson (2007) provides insights into the aging process of older adults and the importance to maintain a holistic balance throughout the aging process. Although the focus of her research is not specific to older adults with mental health concerns, she emphasizes the importance of recognizing aging as a process of living rather than a disease process. She also provides acknowledgment of maintain healthy lifestyles by keeping with mental and physical activities and promoting activities that focus on exercise, stress management, nutrition, and dealing with substance abuse. It is also important to incorporate wellness activities for older adults that include building relationships with others and self-care (p. 71).

Additionally, Tindale, Denton, Ploeg, Lillie, Hutchison, Brazil and … Plenderleith (2011) address awareness around the social determinants of health that have been identified by Community Support Services in Hamilton, Ontario, Canada. According to the authors, the Community Support Services, developed in Canada and in other Western nations, "enable persons coping with health or social problems to maintain the highest possible level of social functioning and quality of life" (p. 662). Examples of services include: food services, transportation services, day programmes, volunteer visiting and caregiver support services (p. 662). The authors have also recognized that as the population ages, services are underutilized and the gap between the need and the number of services increases. Interestingly, the research suggests that this lack of awareness of services creates an even larger gap for communities to provide services. The research also distinguishes awareness from knowledge; awareness being a general understanding of what services exist as opposed to knowledge that involves having

knowledge of what the program itself is or does, where it is located and how to get involved (Tindale et al., 2011, p. 662). With respect to the social determinants of health, the authors address various socio-demographic factors such as gender, education, age, social engagement and supports, income and physical and mental health as barriers that often determine which resources are available according to demographic area. For example, Tindale et al. (2011) argue that older adults themselves play an active role in determining how access to resources is determine. They argue that "persons who are relatively privileged with respect to class, age, gender and ethnicity/race are going to be able to put more resources into play when a health concern needs to be addressed" (p. 662-663); as opposed to individuals who have minimal access to resources due to being in underserved communities. Social determinants of health are vastly based on ones' socio-economic status; those who have access will benefit. However, those who do not have access remain underserved. It is important to recognize the different social factors and then create access to resources in those communities that may require it most.

About Canadian Mental Health Association and Social Programming

Founded in 1918, the Canadian Mental Health Association (CMHA) is a national charity that helps maintain and improve mental health for all Canadians. As the nation-wide leader and champion for mental health, CMHA promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness (CMHA BC Division Annual Report, About Us section, 2016-17, p. 6). Current programming is detailed in the Canadian Mental Health Association Vancouver-Fraser Branch 2016/2017 Impact Report published by the Canadian Mental Health Association Vancouver (CMHA-VF) branch. Although it is not the agency's stated intent, many of the CMHA programs address the social determinants of health for people with mental health concerns.

Existing Programs for Adults

The Canadian Mental Health Association Vancouver Fraser (CMHA-VF) branch offers a variety of programs for participants ranging from housing supports, programs for children and youth, employment supports, wellness programs and programs for adults and seniors alike (https://vancouver-fraser.cmha.bc.ca/programs-and-services/). These programs are working towards creating strength and inclusivity for people with mental illness. A detailed perspective of programs at CMHA-VF that support participants through their recovery journey are presented in the Canadian Mental Health Association Vancouver-Fraser Branch 2016/2017 Impact Report. As the focus of this project is the older adult population, only those programs supporting this population will be reviewed in an effort to determine future programming.

Community and Vocational Integration

Community and Vocational Integration offers programs that include Bounce Back and the ECHO Clubhouse. Lau and Fikowski (2012) provide insight on *Bounce Back: reclaim your health*. "It was implemented in 2008 and is led by the Canadian Mental Health Association's British Columbia (BC) Division. Bounce Back which is a wellness program, offers mental health support to individuals experiencing mild-moderate depression with or without anxiety" (p. 29). According to the Canadian Mental Health Association Vancouver-Fraser Impact Report (2016/2017), the Bounce Back program "helps adults overcome early symptoms of depression and anxiety and to improve overall mental health. Participants learn skills to help combat unhelpful thinking, manage worry and anxiety, and become more active and assertive" (p. 7).

ECHO Clubhouse is another program that helps to "reduces isolation and increases connection to community by providing rehabilitation services, learning growth opportunities,

skill-developing workshops, and building meaningful relationships for those living with a mental illness" (Canadian Mental Health Association Vancouver Fraser Branch Impact Report, 2016/2017, p. 7). Further, Get Set and Connect is a program that "supports towards building community connections and meaningful relationships towards living a mentally healthy life. The program coaches work with individual to integrate this concept by linking adults to leisure activities in their community, building social networks with like-minded individuals, sharing resources, and through providing volunteer and leadership opportunities through the volunteer preparation course, Ready, Set, Go!" (Canadian Mental Health Association Vancouver Fraser Branch Impact Report, 2016/2017, p. 8).

In addition to programs that support community and vocational integration, the Individual Placement Support (IPS) is a program that provides the opportunity for individuals with mental illness to secure and maintain competitive employment with the supports of a Vocational Rehabilitation Counselor embedded primarily on a community mental health team.

In a research study that sampled 454 older adults from two Senior Olympic Games, Heo, Stebbins, Kim and Lee (2013) explore the relationship between serious leisure and health benefits to successful aging, highlighting the preservation of older adult's physical health and general mental health. The authors define serious leisure as individuals having committed orientation toward participation in a particular recreation activity that is personally meaningful to them" (p. 18). They also argue that the correlation among participation in such serious leisure activities including archery, basketball, swimming, dancing and other high intensity activities, lead to successful aging as it allows the individual to achieve personal gains such as developing personal growth, relieving stress and building relaxation and building a sense of belonging in their community all lead to successful aging (p. 19). Additionally, Shvedko, Whittaker,

Thompson and Greig (2018) assert that often, once the older adult population retires, their primary social networks such as recreation and friendships are replaced by family; therefore, the researchers are highlighting the importance of the continuation of incorporating leisure and recreation into their life and exposing them to other older adults who may share similar interests.

From a social determinant of health perspective, older adults are subject to various risk factors if not engaged in activities that provide social and even physical interactions. Caudroit, Stephan, Chalabaev and Le Scanff (2012) discuss a study which examines the self-efficacy in the relationship between age, the intention to engage in physical activity and breaking away from an ageist stereotype. The results of study indicate that those individuals who feel younger than their stated age were more inclined to participate in physical activities. The study acknowledges that people who feel older than their stated age present increased mortality risk (p. 493). The study acknowledges that physical activity could improve the confidence and performance of older adults. Additional findings that focus on the social determinants of health are from Haslam, Cruwys and Haslam (2014). They assert that group engagement of older adults including access to community resources kept the older adult population mentally active and independent for a longer period of time. Similarly, the researchers explain that the construct of a social identity is created best when older adults are a part of a membership that can influence health outcomes throughout their impact on other individual's lives who may be in a similar position. The researchers assert the "idea that social groups (e.g., family, friendship, religious, community, and recreational) provide an important and distinctive basis for self-understanding because they furnish people with a sense of themselves as part of a larger collective" (p. 58). Building relationships and participating in social settings makes for a healthier and less isolating life for

the older adult population. This can dramatically decrease symptoms of decline in mental health and isolation, and increase feelings of self-worth and community.

Similar research supporting social determinants of health is presented by Petryshen, Hawkins and Fronchak (2001) describing the effectiveness of social and recreational programs for individuals with mental health concerns and the correlation to successful aging. The research describes the results from a program evaluation to determine the effectiveness of a community program developed for individuals with mental health concerns. Individuals with mental health concerns who participated in the program reported "low levels of general life satisfaction and relatively high levels of loneliness at the time of intake" (p. 295). The findings also suggest that individuals living with a mental illness have the capacity to build successful personal relationships and participate in meaningful recreational programs and activities, therefore enhancing their quality of life and overall well-being.

Housing Programs

The Canadian Mental Health Association Vancouver Fraser (CMHA-VF) branch offers a wide range of supports and services to individuals at risk of homelessness including Homeless Outreach, Community Living Support and Supported Independent Living and Transitional Housing. First, the Homeless Outreach program supports those individuals at risk of experiencing homelessness by supporting them to access housing, and a stable source of income. The agency offers other levels of support such as initiating other community mental health services or a mental health team, all while working with the client and outside community agencies to further develop life skills (Canadian Mental Health Association Impact Report, 2016/2017, p. 9). In addition to the Homeless Outreach Program, CMHA-VF has provided support in housing individuals, including older adults, through programs including Community

Living Support and Supported Independent Living, Transitional Housing and Youth Supported Independent Living.

According to the Canadian Mental Health Association Vancouver Fraser Branch Impact Report, 2016/2017, the Community Living Support and Supported Independent Living program is client-centered, working with individuals with mental illnesses residing in New Westminster, British Columbia to develop independent living skills. They do this by building strength and education around navigating systems such as income assistance, old age pensions, primary health and employment (p. 10). Additionally, individuals in the Transitional Housing program "work with staff to acquire the skills they need for everyday living while regaining a sense of social inclusion through activities at community centres, clubhouses, and local libraries" (p. 10). According to the statistics provided in the report, of the 86 individuals that were placed in housing, 8 of them were seniors (p. 10). Clair, Daniel and Lamont (2016) argue that "structural-level mechanisms involve the unequal distribution of resources and that stigmatizing ideas motivate and justify discriminatory treatment, with both direct and indirect health consequences," (p. 224). In order to eliminate stigma and the marginalization of a vulnerable population such as the older adult population, government policies on mental health housing that will presumably foster change and encourage support for these individuals need to be fully addressed. Recent policies and developments from the provincial levels for mental health housing are attempting to address the needs of the vulnerable population by involving supporting agencies and organizations. According to the Canadian Institute for Health Information (2007), "Canada's provinces are responsible for administering and delivering health services. A number of provinces have developed specific initiatives, plans, frameworks or similar structures pertaining to mental health to guide their policies and services and specifically address issues

related to homelessness and the provisions of supportive housing," (p. 37). Specifically observing into British Columbia, another approach the provincial government is taking is allocating funding to health authorities such as Fraser Health, Vancouver Coastal Health and non-profit agencies such as the Canadian Mental Health Association and Coast Mental Health. Patterson, Somers, McIntosh, Shiell, Frankish and Van der Leer (2007) address how the health authorities "have developed Regional Housing Plans in an effort to build a broader continuum of housing for people with SAMI (Severe Addictions and Mental Illness)," (p. 28). Fraser Health Authority addressed recommendations based on the needs of their clients and some of them include "the development of 135 specialized residential care beds, 225 supported housing units and 525 subsidized rental units. On the other hand, Vancouver Coastal Health recommended to take their project for mental health and addictions housing over the next ten years and "estimated that a total of 2,200 new units will be required to meet the estimated need (725 low and moderate barrier units; 800 mental health supported housing units; and 675 addictions supported housing units)," (p. 29). Specifically, the provincial government's involvement in allocating funding at the municipal level demonstrates that the need for mental health housing is being acknowledged, the area and density of the vulnerable population is being reviewed, and further initiatives may be taken to develop additional mental health housing in the future.

Additionally, when housing is perceived in a positive light by individuals (i.e., a neighbourhood with a safe community), it can have a greater positive influence on one's health and well-being as opposed to any influence of structural disadvantages. For example, the researchers found that "blighted neighbourhoods and the stigma attached to them is internalised by residents and becomes part of their psychological make-up" (Jones, Heim, Hunter and Ellaway, 2014, p. 188). This includes poverty stricken and deprived neighbourhoods with low

socioeconomic statuses that further create a disadvantaged neighbourhood for many who then associated to depression, substance abuse and low self-esteem. Additionally, Gale, Dennison, Cooper and Sayer (2011) agree that older adults living in neighbourhoods that have an increase in socioeconomic deprivation has been linked with a higher prevalence of anxiety and depression (p. 867). This study consisted of 1,157 men and women between the ages of 69-78 years living in Hertfordshire, UK. The researchers "found that people who had a stronger sense of neighbourhood cohesion or who reported fewer problems with their neighbourhood had higher levels of mental wellbeing or positive mental health" (p. 870). Therefore, from a social determinant perspective, it can be argued that an individual's wellbeing and mental health is determined by one's environmental conditions.

Peer Services

Moreover, there are two programs that support individuals to navigate appropriate services and resources who struggle with a mental illness. According to the Canadian Mental Health Association Vancouver Fraser Branch Impact Report, 2016/2017, the two programs are Peer Navigator and Peer Support. Here, "Peer Navigators, drawing on their own lived experience and knowledge, help to break down barriers to accessing services and connect individuals to services such as legal aid, housing, health efficiency in a timely manner" (p. 11). Additionally, for some older adults, help-seeking behaviours increase the internalization of shame and stigma; resulting in those who are particularly unlikely to seek professional supports for mental health issues (Kessler, Agines and Catherine, 2015, p. 186). Many individuals are accustomed to independent living, and help-seeking may bring forward feelings of shame and vulnerability. However, Peer Support Workers play an important role in supporting individuals with a mental illness "to identify and achieve their own goals and wellness plan, which connects

individuals to their communities, access appropriate services, and to achieve a productive and mentally healthy lifestyle" (p. 11).

Social Enterprise Services

Two social enterprise services are offered through CMHA-VF which support individuals with a mental illness to access affordable shopping in their community. First, the Treasure Chest Thrift Store located in New Westminster, British Columbia "operates as a social enterprise with all revenue generated supporting the programs and services of CMHA-VF" (Canadian Mental Health Association Impact Report, 2016/2017, p. 12). Second, the Willow Bean Café "provides competitive employment in a supported work environment to those living with a mental illness" (Canadian Mental Health Association Impact Report, 2016/2017, p. 12). The Café was unfortunately closed on March 31, 2017; however, during the time it was open the program provided individuals with the opportunity to gain training, skills development and receive certification that helped individuals return to both education and employment thereafter.

Prevention and Education

Prevention and education programs are unique in reducing stigma and improving one's quality of life. The Chinese Mental Health Promotion Program is a unique program that has been offered to individuals in the Chinese community for over 20 years "by promoting wellness through recreational and leisure activities, increasing awareness of mental health issues and reducing the stigma associated with mental illness" (Canadian Mental Health Association Impact Report, 2016/2017, p. 13). This program is offered by hosts in both to both Cantonese and Mandarin speaking individuals and focuses on various topics including depression and anxiety, grievance, money management, working with emotions, etc. According to the Canadian Mental

Health Association Impact Report, 2016/2017, due to the fact that this is a specialized program specifically for the older population, CMHA-VF supported 543 seniors in 2016/2017 (p. 13).

Several other English-language programs that promote community outreach and education are also offered to adults to reduce stigma, engage individuals in their communities and to essentially improve the quality of ones' life. Programs that provide stigma-reducing workshops, training and support for community partners including employers and first responders such as Fire Fighters; building resiliency in the workplace and identifying the signs and symptoms of mental illness include Responding with Respect, Resilient Minds – Building the Psychological Strength of Fire Firefighters, Resilient Minds in the Workplace and Mental Health First Aid (MHFA), (Canadian Mental Health Association Impact Report, 2016/2017, p. 14-15). Also, Living Life to the Full (LLTTF) is a program that "helps individuals to feel better and deal with everyday life challenges by learning better self-management skills using Cognitive Behaviour Therapy (CBT) principles" (Canadian Mental Health Association Impact Report, 2016/2017, p. 15). This is an evidence based workshop offered to both adults and youth.

Furthermore, there are several additional programs that support the prevention of stigma around mental illness by educating members of the community. According to the CMHA-VF 2016/2017 Impact Report, the Suicide Prevention Training "prepares and educates members of the community to be the help for people who are at risk of suicide" (p. 16). This program encourages all individuals including community organizations and family members to participate in building effective knowledge and the skills to intervene when helping those in crisis situations. Also, WRAP: Wellness Recovery Action Plan is a holistic program that "supports individuals to explore who they are, discover their strengths and resilience" (p. 16). The focus is on individual self-determination and recognizing that it is the individual who is the expert of

their own life. WRAP is facilitated by program participants who have completed the training. Also CMHA-VF has Counselling and Adult Support Groups. Counselling services are offered at the Delta Resource Centre which is also a centre for individuals to attend who receive mental health resources. "The Centre also hosts a Therapeutic Volunteer Program for adults on disability and can build skills and confidence required for the workplace" (p. 18). Additionally, low-cost "services available include clinical counselling for children, youth, adults and seniors, group/couple's therapy, functional assessment, educational and career counselling, nutritional support, life skills coaching, training, advocacy and Art and Expressing Therapy" (p. 17). The program specializes in "anxiety, depression, anorexia, bulimia, borderline personality disorder, bi-polar, OCD, autism, grief and loss, addictions, trauma, and crisis" (p. 17). Additionally, Adult Support Groups offer a safe and secure environment to adults living with a mental illness. The group is co-led by peers, a Registered Clinical Counsellor and the two groups are Obsessive Compulsive Disorder (OCD) Support Group and Mental Health Resiliency Support Group (p. 17). Lastly, ORCA – Opportunities for Recreation and Community Access is a program that "engages tenants in meaningful and motivating activities, creating inspiration to each individual to reach their potential and to live a full and productive life" (p. 18). Of the 1,276 BC Housing tenants who accessed the ORCA program, 534 were seniors (p. 18). In an effort to reduce stigma and promote recovery and wellness, it is evident that CMHA-VF offers a wide range of programming to support the needs of adults and older adults.

Gaps in the Literature

There is limited literature that speaks directly to the question of programming for older adults in the context of Canadian Mental Health Association programming. There were a number of articles that focused on recommendations and suggestions that would be taken into account

from community partners, stakeholders and family members of service users. Further research is needed on de-emphasizing formal mental health services such as community mental health teams embedded in the medical model system, and emphasizing and identifying the needs of service users by building capacity for participants and encourage ongoing community engagement with other non-profit resources (Pomeroy, Trainor & Pape, 2002, p. 14). More attention to rural and northern community issues in mental health is also needed, as the correlation between ones' health status in relation to the remoteness of location, geographic disparities in access to mental health services, and the social and systemic inequalities are noted (Rural and Northern Community Issues in Mental Health, 2009, p. 3). There is minimal literature that addresses mental health information for seniors in rural communities, especially seniors and those that are First Nations living in rural British Columbia.

Additional gaps in the literature are related to social work and inclusivity – honoring the voices and perspectives of service users. In much of the literature, it is acknowledged that the voices of those adults with mental health concerns, and their families, are not included in decision making processes for programs and services. An integration of this perspective is often a recommendation that is made and highlighted in most of the literature. Therefore, further literature is required that emphasizes the perspectives of service users and is embedded in the research. There is also a need for specific literature that informs policies and practices of CMHA, as well as literature that focuses on the gaps in services and access to services for the older adult population with mental health concerns at a both provincial and national level. From a social work perspective, further research that focuses on CMHA as a nation-wide agency specifically, and tying in perspectives of older adult service users' experiences is encouraged.

Theoretical Framework

Life Span Development Perspective

As human beings, we are exposed to various stages in life. Each stage has challenges tensions which are both positive and negative in certain aspects. In assessing life span development stages, and how they impact older adults with mental health concerns, Erik Erickson's theory of psychosocial development provides a framework. Throughout Erickson's theoretical framework, he contextualizes aging as a transitional phase in life where changes occur in both physical health and social interactions (Graves and Larkin, 2016).

Erikson's psychosocial theory proposes a life span model of human growth and development, which is comprised of eight stages. Each stage represents a unique transitional phase beginning as early as age 0 to later adulthood and death. Graves and Larkin (2016) explain Erikson's various stages of human development along with the search for autonomy within each stage. Webster, (1983, p. 118 as cited in Graves and Larkin, 2016) defines autonomy as "the quality or state of being self-governing; a self-governing state; self-directing freedom and especially moral independence" (p. 62). In early stages of development for children, they are dependent on the caregivers who are often the adults and older adults. It then becomes the role of the adult to be autonomous in having sound judgment. The two stages that are reflective of what the roles and expectations are of older adults are in the seventh stage (generativity vs. stagnation) and the eight stage (integrity vs. despair).

Erikson's seventh stage involves individuals in middle adulthood, and the passing on of knowledge to the individual's children and grandchildren is highlighted. The focus is no longer on the growth of the self, but rather on providing knowledge and guidance to others. In this

stage, the older adult often attempts to remain connected with their peers and relies on interdependent relationships with family and friends (Graves and Larkin, 2016, p. 66). Additionally, in later adulthood, in the eighth and final stage of human growth and development, Erikson explains that individuals find true acceptance of one's self and the life's work they achieved. It is a stage that involves self-reflection of the relationships that were built and reflect on whether the life lived has been worthwhile. However, if the reflections are a negative outlook on life then the person may endure feelings of despair and fear death (Graves and Larkin, 2016, p. 66).

However, what happens when an older adult is no longer able to make decisions due to a decline in one's physical and mental health? Critically reflecting on Erikson's life span development theory, some questions remain around how older adults with physical and mental health concerns are impacted; whether it is a loss of relationships including family and peers, death of a loved one (including partners), and experience social isolation and dealing with the decline in one's physical health.

Turesky and Schultz (2010) argue that many of the concerns pertaining to an older adult's physical and mental health can be reversed through spirituality and creating connections with others alike. These researchers suggest that by incorporating spirituality and religion into one's life can lead to a decline in mental health related concerns such as anxiety and depression, and lessen physical health concerns as a result of attending religious institutional activities and creating connections with peers through attending both religious and recreational groups (Turesky and Schultz, 2010, p. 169-170).

Moreover, Vogel-Scibilia, McNulty, Baxter, Miller, Dine & Frese (2009), who are all both authors and consumers with serious mental illness, highlight the importance of

implementing recovery into one's psychiatric care at various life stages, including middle and older adulthood. The authors explain that an individual's recovery is instilled by various components including: empowerment, holistic, strengths-based, peer support, respect and hope (p. 405-406). The authors argue that Erikson's phenomenon is linear and sequential in which each life stage has its specific set of expectations and one is limited to the experiences in that current stage. However, a recovery framework is a progression of different experiences which at the end contribute to one's journey of recovery. The authors specifically endorse support from peers, incorporating meaningful recovery activities such as volunteer work and/or employment, and acknowledging that the process of recovery in psychiatric care as important in middle and late adulthood.

Design and Methodology

The intent of this research was to review staff perspectives based on their experiences working with the older adult population, of what programming is required, by reviewing existing programs that are available to the older adult population with mental health concerns at the Canadian Mental Health Association Vancouver-Fraser (CMHA-VF) branch. The research also included participants from CMHA North and West Vancouver, Shuswap-Revelstoke and Kelowna branches as a way to learn from the perspectives of front line staff about programs that are offered and how as an agency, we can improve programming and have other branches learn about them from each other also. Data was collected using an online survey. This study was cross-sectional and used both qualitative and quantitative methods. Dudley (2011) explains that "qualitative surveys are intended to be exploratory, and the questions they ask encourage an elaboration of a point rather than a standardized response that can be reduced to a numerical score. Qualitative interviews (surveys) are flexibly administered so that they can be responsive

to each participant's circumstances and the unique dynamics of each interview" (p. 169-170). The questions encouraged participants to share their views as front-line staff who work with clients, and what they determine to be effective programs for older adults versus in their view, what they believe their agency may be able to benefit from, for future programming.

Recruitment

The recruitment process began once approval had been obtained from the University of the Fraser Valley's Research Ethics Board on March 28, 2017 (Appendix A). The Executive Directors from CMHA North and West Vancouver, Shuswap-Revelstoke and Kelowna branch were contacted via email (Appendix B), to first inform them of the project and request their support for this research. I obtained a letter of support from CMHA-VF to show that my employer was supportive of this project. I also obtained a letter of support from the other CMHA branches to confirm participation. I also attached a staff recruitment letter (Appendix C). I obtained permission from all of the Executive Directors via letters of support (Appendix D). Through the Executive Directors, I requested the email addresses of only those staff who worked directly with all clients, including older adults, in various programs. As an employee of CMHA-VF branch, I was permitted to access to my agency's staff list with the assistance of my program manager. The purpose of this research was to gain insight from staff only, so email addresses of management were excluded/not collected. The online survey was created using FluidSurveys. The link to the online survey was sent from my CMHA-VF work email address, providing a brief introduction to all participants, along with the staff recruitment letter. I asked each potential participant to identify their branch, and in their view, what programs are effective, and what other programs they thought could be implemented to serve the older adult population with mental health concerns. Participation in the survey was voluntary; as participants had a

choice to complete the survey. Dudley (2011) explains studies that involve questionnaires, the informed consent information can be included in a letter or in the questionnaire itself. After participants review the informed consent, if participants completed the survey it was assumed to be voluntary (p. 45). This was stated clearly at the beginning of the online survey. Participants were not required to sign a consent form, as agreeing to partake in the survey and submitting it was considered consent. The link to the survey was open for 10 days and officially closed on April 21, 2017. All of the data collection occurred via FluidSurveys.

Data Collection and Analysis

Data was collected through semi-structured survey questions using FluidSurveys. A list of survey questions (Appendix E) was prepared that included both closed and open-ended questions in order to obtain qualitative data. Demographic questions were included which asked participants to identify their branch and the number of years they worked at their respective branch. Using open-ended questions allowed participants to have the flexibility of providing in-depth and descriptive responses pertaining to their views and experiences of working in various programs. A total of 222 participant email addresses, excluding management, were identified from all four CMHA agencies, and the survey was sent to all of them. The data from FluidSurveys based on 42 completed responses was used. Even within the responses, not all participants answered every question. Surveys that were incomplete, or missing data were counted among the 42 analyzed. Participants were asked twelve questions in total, though two of them were two-part questions. Therefore, the survey had a total of fourteen questions with a combination of open-ended and closed responses.

In addition, once the link to the survey was closed, the responses to the open-ended questions were summarized and categories evolved from participant's feedback. The results

from the survey were compared across the four CMHA branches to identify the perceived need for additional programming for the older adult population. The categories also helped to identify staff members' perceived challenges for the older adult population with mental illnesses when attempting to access programming, and opportunities for new, older adult specific programming. A thematic analysis was conducted in order to identify central themes that evolved from the survey questions from participants. First, I reviewed each and every response received from participants. Upon going through the responses thoroughly, I was able to identify themes based on the responses. As Dudley (2011) explains, "a theme is an idea, viewpoint, or conceptualization of something that is repeated over and over in qualitative materials" p. 259). Dudley (2011) also indicates that themes can also be abstract. There were many repetitive, common answers from the responses. "These repetitious ideas will not necessarily be stated every time using the same words or phrases, particularly when they are at a higher level of abstraction" (p. 259). Therefore, the repetitive responses essentially became themes. Using the coding system (Dudley, 2011, p. 260), I colour coded whenever similar themes emerged. Many of the responses also had more than one theme. Next, I organized themes according to each survey question and that was how my thematic analysis was completed. The analysis of the data included coding and categorizing of open-ended questions, and descriptive statistics of closed questions that were just that, descriptive that summarized and described my data. I generated a report by using the 'Export Responses' function, and that generated all responses according to the specific questions. I used the FluidSurveys program to generate the data from my survey; including charts and graphs. Upon completion of this research, the raw data was kept securely stored on a password protected USB. The final task of this project will be to share the results

from the findings with all of the partnering CMHA agencies and to also share this project online in the UFV library.

Ethical Considerations

I received ethical approval from the University of the Fraser Valley's Research Ethics Board on March 28th, 2017 (Appendix A). Several ethical implications were considered with this study. The first is "suffering from a conflict of interest because I am a staff member" (Dudley, 2011, p. 48). In order to avoid any conflict from management and staff, I included a statement in the staff recruitment letter indicating that *the purpose of this research is to focus on the clients we serve and their needs, and to look at CMHA VF as a tool for how it can support our older adult clients with mental health/illnesses.* I have an obligation to ensure that the dignity, rights, safety and protection of staff is valued and honoured. As previously mentioned, the survey was voluntary and did not require staff to identify personal information. However, staff were required to identify themselves by their branch, and a smaller branch with a small sample size could violate their anonymity. Therefore, "the researcher must make every effort to ensure that confidentiality is honoured in a study. While anonymity is typically not a requirement for a study, assurance of anonymity can sometimes be helpful in encouraging participants to respond to a questionnaire study as openly and honestly as possible" (Dudley, 2011, p. 43).

Participants were not able to withdraw from the survey once they had submitted it, as it was an anonymous survey and therefore, individual surveys could not be identified or withdrawn. I was required to have access to all staff members' email addresses which I received from my program manager and the Executive Directors of each branch. However, the results returned to me by FluidSurveys remained anonymous. This research was very minimal risk. The

questions were professional and neutral in tone. The HREB Approval Certificate for this project indicated that "*The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research."* All of the data and the FluidSurveys report is saved on a password protected USB and/or stored in a locked cabinet. This project may be used for future presentations and may be submitted for publication; therefore, data and material will not be immediately discarded.

Findings

A Demographic Summary

Participants in this study included staff members from the Canadian Mental Health Association Vancouver Fraser Branch, Shuswap-Revelstoke, Kelowna and North and West Vancouver Branch. These findings will serve as a tool for branches to learn from each other around what programs are priorities based on participants' views. A total of 42 participants identified their branch. Twenty participants identified with Vancouver-Fraser, 11 with Kelowna, 6 with Shuswap-Revelstoke and 5 from North and West Vancouver. Twenty-six per cent of respondents identified as being employed with CMHA for less than one year, 21.4 per cent indicated they had been employed between 1-2 years, 11.9 per cent were between 3-4 years, 7.1 per cent were between 5-6 years, 9.5 per cent between 7-8 years, 4.8 per cent between 9-10 years and 19 per cent identified being employed with their branch for more than 10 years. The median of participants (11.9 per cent) identified as being employed between 3-4 years.

Thematic Categories

Five thematic categories were identified: **stigma, education and outreach, leisure/recreational/social wellness programs, how to access resources, and future older adult programming**. In order to identify these five categories, I conducted a theme analysis. According to Dudley (2011), a "theme analysis is useful in analyzing lengthy narrative material of a participant observation or unstructured interview study" (p. 257). However, in this research, a theme analysis was used to analyze unstructured, open-ended survey questions.

First, I determined the unit of analysis. I referenced five open-ended survey questions that provided in-depth responses from participants. These questions were used as they provided the opportunity to receive answers from participants' that would serve as a learning tool for future older adult programming. Then, I went through each participants' responses and as I read through the responses, I began to identify themes that seemed to pop. Those themes were primarily viewpoints and perspectives of participants. I saved participant's narratives from FluidSurveys on a separate digital file. Each of the five open-ended survey questions had several themes or viewpoints that evolved from participants' narratives. I reviewed participants' responses several times, and determined that to be the thematic category based on the number of responses. Additionally, I used charts that also provide details and a breakdown of categories.

Stigma

One of the questions which highlights the perceived role of stigma in older adults' mental health asks: *In your view, what is the biggest challenge facing the older adult population with mental health issues when accessing programming?* Thirty-nine responses were received for this question (please refer to Table 1). From those responses, thirteen categories were identified. The categories include: decline in health, funding, isolation, lack of affordable housing, lack of

family support, lack of knowledge around mental health, lack of technical skills (such as out-dated computer skills), limited to no adult programming available, poverty, stigma, substance use/misuse, transportation and other. The 'other' category includes responses that did not fit into any of the categories. Examples of this include: "*I have no issues or challenges or, the amount of support one needs may be more than what CMHA offers*."

Table 1. Challenges facing the older adult population with mental health issues when accessing programming.

Response	Chart	Percentages	Count
Decline in Health		9%	5
Funding		5%	3
Isolation		9%	5
Lack of Affordable Housing		12%	7
Lack of Knowledge around Mental Health		1%	1
Lack of Technical Skills		5%	3
Lack of Family Support		1%	1
Limited to No Adult Programming		7%	4
Other		9%	5
Poverty		1%	1
Stigma		20%	11
Substance Use/Misuse		1%	1
Transportation		14%	8

Twenty percent of participants identified stigma within their answers. Fourteen percent of participants felt that access to transportation was a challenge. Twelve percent reported that lack of affordable housing was an issue. Based on the above response, participants believed that older adults are subject to stigmatization when accessing services. When asked participants'

what they felt is the biggest challenge facing the older adult population with mental health issues when accessing programming, one participant stated, "*Maybe stigmatism. Maybe just knowledge of mental health and things to do to be well mentally."* Another participant expressed, *"Stigma, differing views between generations."*

Additionally, another participant expressed one of the biggest challenges being, *"Existing stigmas most likely, in my opinion, prevent the aging population from accessing programming. This may be due to lack of information and an old school way of thinking about mental health."* A participant also indicated how:

> *"Mental [health] gets deprioritized below physical needs. Older people are not seen, their mental health concerns even less so. As people age they become even less able to advocate for themselves and if they mental health issues their vulnerability is magnified."*

The above responses from participants' capture their perspective on why they felt stigma was a barrier to older adults when accessing programming.

Education & Outreach

Another question asks: *From the below list of possible programming opportunities, which do you feel is most necessary*? *Please rate your 'choice' from 1 – absolute need to 5 – least necessary*. This question allowed for a Likert scale response option. Forty-two participants responded to this question. Thirty-eight percent identified an absolute need for education and outreach supports for older adults as opposed to 40.5 percent of participants who indicated that employment services were least necessary. Table 2 below illustrates the findings in greater detail.

Table 2. Possible programming opportunities.

	Choice 1	Choice 2	Choice 3	Choice 4	Choice 5	Total Responses
Living Life to the Full for Older Adults	10 (23.8%)	9 (21.4%)	10 (23.8%)	5 (11.9%)	8 (19.0%)	42
Employment Services for Older Adults	8 (19.0%)	2 (4.8%)	7 (16.7%)	8 (19.0%)	17 (40.5%)	42
Cognitive Behavioural Therapy groups for Older Adults	7 (16.7%)	15 (35.7%)	8 (19.0%)	8 (19.0%)	4 (9.5%)	42
Education and Outreach	16 (38.1%)	7 (16.7%)	7 (16.7%)	9 (21.4%)	3 (7.1%)	42
Recreational Programming for Older Adults	14 (33.3%)	8 (19.0%)	7 (16.7%)	8 (19.0%)	5 (11.9%)	42

Participants were provided with these five options to gain insight on existing programs offered throughout the four CMHA branches, and to identify staff perspectives of these programs. Based on a response rate of 38.1 percent to this question, participants identified education and outreach as an absolute need for older adults. One participant indicated that *"Education and outreach [is important] to get people understanding what mental health and wellness is and what programs are available."* Additionally, another participant expressed that there needs to be *"more education about mental illness."* These participants' perspectives suggest a need for further education and outreach services for older adults.

Leisure/Recreational/Social Wellness Programs

Another question on the survey asked participants to help identify existing program(s) within their respective CMHA branches that offer services to older adults with mental illness.

This question was asked to gain perspective on what programming exists. Participants provided a list of programs offered throughout the four branches, as identified below in Table 3.

Table 3. Existing programs offered to older adults at CMHA.

Response	Chart	Percentages	Count
Bounce Back		6%	3
Cognitive Behavioural Therapy		4%	2
Clubhouse		6%	3
Employment		9%	4
Get Set & Connect		2%	1
Living Life to the Full		2%	1
None		6%	3
Not Sure		9%	4
Other		9%	4
Peer Support		6%	3
Residential Mental Health Care		2%	1
Seniors Wellness Groups: including art, rec, education, fitness, health, meet-up groups, supports to access resources, etc.		30%	13
Wise and Well		2%	1

Out of thirty-four responses, twelve programs were identified based on the feedback from participants. These included: Bounce Back, Cognitive Behavioural Therapy (CBT), Clubhouse, Employment, Get Set & Connect, Living Life to the Full, None, Other, Peer Support, Residential Mental Health Care, Seniors Wellness Groups including art, recreation, education, fitness, health, meet-up groups, supports to access resources, etc., and Wise and Well. Of note, 9 per cent identified to not being sure about existing programs. A program that stood out from this question was the Seniors Wellness Groups in which 30 per cent of respondents identified it is a

need for older adults. When I conducted a cross-tabulation to determine the number of staff from each branch that supported this view and identify the branches offering programs to older adults, I was able to identify that of the 13 participants who identified with Seniors Wellness Groups. Interestingly enough, the program Wise and Well: Building Mental Fitness for Older Adults was only identified by one participant as needed by the older adult population. This is an 18-month project with the goal of reducing isolation and feelings of loneliness among older adults in the central Okanagan. The program connects volunteers with mental health training and matches them with older adults to assist them in building meaningful social connections within their communities (CMHA Kelowna Branch, 2018). When asked participants to identify what existing program(s) their CMHA branch offers to older adults with mental illnesses, one participant indicated: "*The Wise & Well project isn't really programming for older adults, but it provides training for volunteers who work with older adults."* Related information is presented in Table 4 below.

Table 4. Wise and Well as an existing program offered to older adults at the Kelowna CMHA.

Response	Vancouver-Fraser	Kelowna	Shuswap-Revelstoke	North + West Vancouver	
Bounce Back	1 *33.3%*	0 *0.0%*	0 *0.0%*	2 *66.7%*	*Total:* 3
Cognitive Behavioural Therapy	0 *0.0%*	0 *0.0%*	0 *0.0%*	2 *100.0%*	*Total:* 2
Clubhouse	2 *66.7%*	0 *0.0%*	1 *33.3%*	0 *0.0%*	*Total:* 3
Employment	3 *75.0%*	0 *0.0%*	0 *0.0%*	1 *25.0%*	*Total:* 4
Get Set & Connect	1 *100.0%*	0 *0.0%*	0 *0.0%*	0 *0.0%*	*Total:* 1
Living Life to the Full	1 *100.0%*	0 *0.0%*	0 *0.0%*	0 *0.0%*	*Total:* 1
None	2 *66.7%*	0 *0.0%*	1 *33.3%*	0 *0.0%*	*Total:* 3
Not Sure	2 *50.0%*	2 *50.0%*	0 *0.0%*	0 *0.0%*	*Total:* 4
Other	2 *50.0%*	1 *25.0%*	0 *0.0%*	1 *25.0%*	*Total:* 4
Peer Support	2 *66.7%*	1 *33.3%*	0 *0.0%*	0 *0.0%*	*Total:* 3
Residential Mental Health Care	0 *0.0%*	0 *0.0%*	0 *0.0%*	1 *100.0%*	*Total:* 1
Seniors Wellness Groups: including art, rec, education, fitness, health, meet-up groups, supports to access resources, etc.	3 *23.1%*	6 *46.2%*	4 *30.8%*	0 *0.0%*	*Total:* 13
Wise and Well	0 *0.0%*	1 *100.0%*	0 *0.0%*	0 *0.0%*	*Total:* 1

Research participants also identified the need for more Seniors Wellness Groups. Again, when participants were asked to identify what existing program(s) their respective CMHA branch was offering to older adults with mental illnesses, one participant felt the need for *"Wellness Development Centre, including ArtWork Studio, offering recreational, educational, and skills-related programming;* while another participant expressed how they *"offer a coffee time for older adults, housing programs is offered to older adults and we do occasional activities/outings that appeal to older adults."*

How to Access Resources

Furthermore, the survey asked: *From your experience what type of education is needed for older adult clients?* I received thirty-eight responses and constructed fifteen categories based on the responses. The categories include: Cognitive Behavioural Therapy (CBT), Computer Skills including all technology; Dealing with Loss/Death, Education around Seniors Benefits, Elder Abuse, Food and Nutrition, Health and Safety; How to Access Resources, Mental Health Education, Peer Led (Seniors Helping Seniors), Self Care, Seniors Education, Substance Abuse, Vocational and Volunteer and Work. Three per cent of participants were not sure about the type of education they felt was needed for older adult clients. Twenty- three percent of participants felt that the older adult population required further education on accessing resources. Table 5 below highlights these findings.

Table 5. Types of education identified as needed for older adults.

Response	Count	
Cognitive Behavioural Therapy	3 *5.4%*	
Computer Skills: including all technology	7 *12.5%*	
Dealing with Loss/Death	2 *3.6%*	
Education around Seniors Benefits (Government)	4 *7.1%*	
Elder Abuse	1 *1.8%*	
Food & Nutrition	2 *3.6%*	
Health & Safety	2 *3.6%*	
How to access resources	13 *23.2%*	
Mental Health Education	8 *14.3%*	
Not Available	2 *3.6%*	
Peer Lead (seniors helping seniors)	1 *1.8%*	
Self-Care	4 *7.1%*	
Seniors Education (school)	2 *3.6%*	
Substance abuse	1 *1.8%*	
Vocational	2 *3.6%*	
Volunteer & Work	2 *3.6%*	

Approximately fourteen percent of participants felt that mental health education was needed and 12.5 per cent of participants felt that older adults required all aspects of computer skills training. Participants shared their views and perspectives on what they felt was required as priority supports. When asked participants to explain from their experience, what type of education is needed for older adult clients, one participant indicated that there is a need for *"Education helping them to manage life with limited resources."* Another participant indicated the importance of *"Education/information as to what they can access in the community, and what their rights are;"* and a third participant expressed the importance of having *"Information on what programming is available for them, low cost to free would be good as many older adults are on a fixed income."*

Future Older Adult Programming

To determine region-specific information, I conducted a cross-tabulation to determine how many participants from specific branches would want to see as a program implemented by CMHA that would better serve the older adult population. According to the results, of the 18 participants that felt an education and outreach program was important to implement in the future. Table 6 highlights this information below.

Table 6. Program priorities for older adults.

Response	Vancouver-Fraser	Kelowna	Shuswap-Revelstoke	North + West Vancouver	
Addictions Programming	0 *0.0%*	1 *100.0%*	0 *0.0%*	0 *0.0%*	*Total:* 1
Cognitive Behavioural Therapy	0 *0.0%*	2 *100.0%*	0 *0.0%*	0 *0.0%*	*Total:* 2
Counseling Services	0 *0.0%*	0 *0.0%*	0 *0.0%*	1 *100.0%*	*Total:* 1
Education & Outreach	8 *44.4%*	4 *22.2%*	3 *16.7%*	3 *16.7%*	*Total:* 18
Employment	1 *50.0%*	0 *0.0%*	0 *0.0%*	1 *50.0%*	*Total:* 2
Housing	3 *37.5%*	2 *25.0%*	2 *25.0%*	1 *12.5%*	*Total:* 8
Leisure and Recreation	6 *50.0%*	2 *16.7%*	4 *33.3%*	0 *0.0%*	*Total:* 12
Living Life to the Full	1 *100.0%*	0 *0.0%*	0 *0.0%*	0 *0.0%*	*Total:* 1
Meals and access to food	0 *0.0%*	0 *0.0%*	1 *100.0%*	0 *0.0%*	*Total:* 1
Not Sure	0 *0.0%*	2 *100.0%*	0 *0.0%*	0 *0.0%*	*Total:* 2
Peer Navigator Program	1 *100.0%*	0 *0.0%*	0 *0.0%*	0 *0.0%*	*Total:* 1
Social Wellness Groups	3 *50.0%*	1 *16.7%*	2 *33.3%*	0 *0.0%*	*Total:* 6

Additionally, another question on the survey asks: *In your view, what types of future programs would you like to see implemented by CMHA that would better serve the older adult population? Please provide a brief explanation.* Thirty-six participants responded to this question. The response categories included the following: Addictions Programming, Cognitive Behavioural Therapy (CBT), Counseling Services, Education and Outreach, Employment, Housing, Living Life to the Full in house program, Leisure and Recreation, Meals and Access to Food, Other, Peer Navigator Program and Social Wellness Groups. Two major categories emerged from participant's responses. First, 32.7 per cent of participants felt that education and outreach programs were something they wished to see for future programming within their branch, while 21.8 per cent of participants felt that leisure and recreation was a necessity for future programming initiatives. When participants were asked about the types of future programs they would you like to see implemented by CMHA that would better serve the older adult population, one participant stated, *"[they] feel the existing programs at CMHA are sufficient for the older adult population, however, outreach needs to be improved so the older population is aware that these specific services can be accessed by them."*

Furthermore, the survey also asked the question around whether CMHA should consider being a hub for referrals for outside agencies wanting to refer older adults, and whether participants agreed, disagreed or were not sure. This question received a total of 42 responses and the majority of participants at 47.6 per cent felt that they were not sure about whether CMHA should be a hub for referrals. A lead up question to this asked whether participants felt the older adult population is generally satisfied with what they gain from their program and whether they agreed, disagreed or were not sure. Again, a total of 42 responses were received in

which the majority of participants at 54.8 per cent indicated that they were not sure if the older adult population was satisfied with programs offered at their home branch.

Discussion

Further analysis of some of the participants' statements may indicate that they have exhausted many of the resources available to older adults; however, recognizing that there needs to be awareness around outreach services, addictions programming and independent living tools. Perhaps these views are shared by those participants who currently do not have outreach supports, addictions programming or independent living skills provided to their older adult population.

It appears that there is a need for further education for older adults on how one can access resources. This may be due to a learning curve and the generation gap where the advance in technology has fostered barriers for the older adult population who may not be familiar with the most current technology and how to access resources through it. Perhaps CMHA as an agency can review their policies and incorporate implementation of education around the latest technology for use to the older adult population.

In addition, one of the ways a branch would be able to determine the effectiveness of a program is by conducting a survey or questionnaire and asking for participant feedback. This is a method other branches may want to consider when determining a satisfaction rate from their participants. As noted previously, this inclusion is imperative.

Creating Strength and Inclusivity

One method of creating this strength and inclusivity is through the power of language. Deconstructing language helps to mobilize different meanings and concepts in social work

practice. Mental illness denotes negative connotations and in order to prevent the continuation of this it is imperative to deconstruct language and dominant discourse. Gregory and Holloway (2005) provide an overview of three periods of social work: the moral enterprise (where the social work recipient is seen as morally weak and in need of guidance, p. 40); the therapeutic enterprise (a shift in language occurs where clients are perceived as poor, needy and imbecile to instead 'client' or unique human being. The focus shifts on building relationships between the worker and client; however, the worker takes on professional dominance over the worker, p. 41-42); and the managerial enterprise (where social work is now in a social context emphasizing managing outcomes and is now dominated by the language of risk management and consumerism, p. 46-48). These three periods of social work assess the power of language and how it can shape social work and control its direction.

Strength and inclusivity is built with capacity. One way to achieve this is by including the voices and perspectives of the service users. The findings provide suggestions for prospective programming from the perspectives of front-line staff, as necessities for the older adult population.

In connecting the life span development perspective to older adults and aging, Roberto and Jarrott (2008) state that as older adults age, they frequently rely on family members for supports and a more intensified level of care. The life span perspective acts as a guiding framework to help make connections of older adults, mental health concerns and anti-oppressive practice as means of implementing a holistic perspective to recovery that includes instilling empowerment, hope and respect, and meaningful recovery activities such as volunteer work and/or employment in the middle to older adulthood stages. The authors encourage further collaborations with community partners to promote education to families around health and

recovery; including resources such as community education, support groups and education around respite programs (p. 105-106). An example of this is presented from the findings around a further need for seniors' wellness groups that include education, fitness and supports with healthy living.

Baines (2011) explains that [r]esources like skills, knowledge, and networks are unfairly distributed in society according to class, race, gender, ability, age, and regional privilege. From a social determinant of health perspective, these factors exclude marginalized populations from obtaining appropriate living conditions that enhance quality of life and instead create a larger barrier that deter the vulnerable from equal access to resources. Gilleard and Higgs (2015) argue that instead of framing the life span of age as a dynamic stage in life that has its own set of barriers, instead, the focus remains on what early life conditions and crises caused such health and/or economic conflicts (p. 307). This research is relative to the findings as it provides insights as to why some older adults may be experiencing challenges when accessing resources.

Limitations of the Study

Several limitations were identified within this study. Firstly, the survey received a limited response. A link to the survey was sent out to a total of 222 participants from the four CMHA agencies combined, and only 42 completed responses were received. The low response rate may have resulted from several factors. Reasons staff may have declined participation in the survey might include: not having enough time in the employee work day, new staff having limited experience and knowledge around programming at CMHA, the survey was not open and available for a sufficient period of time, or perhaps the questions were not unique enough that would allow participants to identify needs for programming required at their agency. Additionally, I have considered my position as an employee in the organization and the potential

of compromising anonymity based on the identifying information required from participants, such as what branch they work at. Another key limitation was that many of the open ended questions on the survey provided responses from participants where more than one category was identified, creating a challenge when attempting to identify categories. I would have liked to include the voices of older adults in this research, but unfortunately I was constrained by timelines and ethical imperatives.

Other factors to consider include cultural differences and participants' understanding and/or interpretations of mental illness, language barriers, and staff members' personal biases due to negative (or positive experiences) working with the older adult population. As this research was a mixed-methods project, I recognize the challenges that surfaced when having several open ended questions. Open-ended questions can allow participants to provide short or lengthy responses without restriction on length. The survey questions had a general structure; allowing for flexibility and hopes of encouraging thoughtful and meaningful responses. However, perhaps the questions required additional structure in order to produce more definitive answers.

Implications for Policy, Practice and Future Research

Finally, it is also important to consider how CMHA-VF will access funding for additional programming; who will provide the funding? How might CMHA include the older adult population in the decision making process to identify what their needs are for future programming? What other CMHA stakeholders and funders might also be included in the decision making process? Policies and practice should not create barriers but foster engagement among community members while establish and maintain continuous positive relationships. It would also be imperative to consider recognizing the diverse needs of the older adult population.

Perhaps CMHA-VF could also consider establishing a pilot project based on some of the challenges that were identified and addressed by participants, while also including the older adult population to voice their needs and concerns moving forward.

Based on these findings, front line workers identified a need for education for older adults on how to access resources. This is something that CMHA as a whole can work toward and ensure that appropriate tools and education is provided to older adults so that they are well informed about the programs and services they have access to. For example, perhaps CMHA can offer information sessions, build a resource room that welcomes all individuals to drop in to explore resources, and perhaps offer a peer-led computer class where older adults can learn how to use basic computer skills and then would be able to research resources independently. From a social determinant of health perspective, for older adults to have community belonging provides the opportunity to participate in social activities and to become socially engaged and active in their communities. Additionally, Erikson's life span development perspective reviews the various life stages that have both positive and negative effects on the individual. However, with the appropriate measures and integration of positive supports, a healthier older adult population can continue to evolve.

Many participants also felt that CMHA should consider implementing programs that foster both education and outreach. An example of outreach services can include follow-up support phone calls and a Lunch and Learn where older adults can enjoy an affordable to possibly even a free meal accompanied by an informational presentation/education session on a topic of interest to seniors. An example of topics can include healthy living and fitness, and gain knowledge on how to engage in various other community resources. With that being said, a key implication for policy and practice would be to ask who would be involved in the decision

making while implementing such future programs – to create this strength through inclusivity. It is imperative to include the voices of those who require supports and advocacy. Tremblay, Coulombe and Briand (2017) highlight how the Canadian Mental Health Association-Montreal branch has set up an initiative where it is "*mandated to promote the participation of users and carers in the planning, organisation and evaluation of mental health services* in order to improve services and coordinate care by providing a forum where ideas can be exchanged and freely expressed" (p. 2). This is required in order to advocate for change and to acknowledge barriers and needs; to be inclusive of others and to include service-users and their families to be a part of the decision making process for change. Including the voices and experiences of service users to help identify both the gaps and needs of specialized programming that would support specific communities, as well as including families and stakeholders and working collaboratively with service-users to identify additional cultural or diversity needs. There is still much research that needs to be conducted related to the specific topic of how CMHA-VF can implement further programming for the older adult population. Further research that invites and honours the experience and needs of older adults in regard to CMHA programming, and more generally across mental health services, is a priority. Maximizing the engagement of older adults with mental health concerns is important.

Conclusion

The intent of this research was to review existing programs that are available to the older adult population with mental health concerns at the Canadian Mental Health Association Vancouver Fraser (CMHA-VF) branch. Including CMHA North and West Vancouver, Shuswap-Revelstoke and Kelowna branches in this study allowed CMHA as an agency to learn from each other by including staff perspectives on programs that are offered, their perceived

need for future programming, and how other branches can learn from each other on improving programming for older adults.

This research explored various literature around the area of social programming for older adults, the effects of mental health concerns, stigma amongst the older adult population, creating strength and inclusivity and exploring opportunities for community involvement. This research focused on Erik Erickson's life span development theory; specifically, on the middle and older adulthood stages of growth and recovery. This research also explored social determinants of health and the various factors that exclude and marginalize vulnerable populations such as older adults, from obtaining a healthy quality of life, and provided findings from the perspective of front line staff that one day may become a useful tool in creating additional programming for the older adult population with mental illnesses at the Canadian Mental Health Association.

The life span development framework applied Erik Erikson's psychosocial theory of human growth and development to older adults with mental health concerns, while also exploring various social determinants of health that affect the older adult population. Social determinants of health provided a foundation for understanding why certain groups of individuals experience social exclusion and are denied the opportunity to participate in Canadian life. From a social justice perspective, with the development of appropriate policies from stakeholders and policy makers, individuals may have greater autonomy and insights to voice their concerns and needs around future programming. This research also identified five thematic categories from participant's views in the findings: stigma, education and outreach, leisure/recreational/social wellness programs, how to access resources and future older adult programming. Currently, older adults' perceptions, views and needs for programming with the

Canadian Mental Health Association are not well documented or researched. This is indicated as an opportunity for further research.

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Appendix A

Certificate of Research Ethics Board Approval

Certificate of Human Research Ethics Board Approval

Contact Person	Department	Protocol #
Christina Beeching	Social Work	971S-17

Co-investigator(s)

Darryl Fox

Title of Project

Filling the gaps in programming for the Older Adult population with Mental Health issues at the Canadian Mental Health Association Vancouver-Fraser Branch.

Sponsoring/Funding Agency

N/A

Institution(s) where research will be carried out

University of the Fraser Valley; Canadian Mental Health Association Vancouver-Fraser (CMHA VF) branch, Canadian Mental Health Association BC Division branches including: North + West Vancouver, Shuswap Revelstoke and Kelowna.

Review Date:	Approval Date:	Approval Term:
20-Mar-17	28-Mar-17	28-Mar-17 - 27-Mar-18

Certification:

The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.

Michelle Riedlinger, Chair, Human Research Ethics Board

NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.

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Appendix B

Recruitment Email for Potential Participants

Dear [EXECUTIVE DIRECTOR'S NAMES]

My name is Christina Beeching and I am an employee at the Canadian Mental Health Association Vancouver-Fraser Branch. I am also a graduate student at the University of the Fraser Valley and I'm in the process of completing my Master of Social Work degree.

My research question is the following: **How can the Canadian Mental Health Association Vancouver-Fraser Branch fill the gaps for more programming for the Older Adult population with Mental Health issues?**

I am reaching out to you today in hopes of having your support that will assist in my research project for my MSW. I spoke with Michael Anhorn and he recommended your branches as he believes there may be an interest in participating in this project. I am very excited about my research and I feel that your participation will enrich the learning process and will allow all of our branches to learn about specific needs and gaps in programming for the Older Adult population.

I plan on conducting an online survey which will ask staff to identify which branch they are from, which program they are associated with, what current programs are effective in serving the Older Adult population (age 55+) and if they are able to identify any gaps. My hope is that by doing this, staff will be able to provide their insight and knowledge as to what some of the visible gaps are and whether we need to look into further programming initiatives specifically for Older Adults or incorporate/modify existing programs to better serve this population.

I am in the process of completing my research proposal which will be submitted to the Ethics Board at UFV by the end of this month. I would also require a letter of support from each branch to ensure participation.

Also, participation for the online survey would be voluntary but will be encouraged to all staff. Unfortunately, staff will not be able to withdraw from the survey once they have submitted it as it is an anonymous survey and therefore, individual surveys cannot be identified or withdrawn. I would also require your support in gaining access to your staff email list, or if easier, I can email the survey to you for distribution.

Please find attached a template of the letter of support as well as a letter of information for your review. This will highlight the research project and give you a brief outline of the nature of the research.

Thank you very much for your time and consideration. I look forward to hearing from you and I'm hopeful that you will support this research project.

Sincerely,
Christina Beeching, BSW, RSW

Appendix C

Letter of Information

School of Social Work and Human Services
33844 King Road
Abbotsford, BC V2S 7M8

Date: February 21, 2017

Research Project

Filling the gaps in programming for the Older Adult population with Mental Health issues at the Canadian Mental Health Association Vancouver-Fraser Branch

Staff Recruitment Letter

Purpose/Objectives of the Study

My name is Christina Beeching and I am a graduate student at the University of the Fraser Valley and an employee at the Canadian Mental Health Association Vancouver-Fraser (CMHA VF) branch. The purpose of this program evaluation (major project) is to review programs that are already established and available to the Older Adult population (age 55+) with mental health issues at CMHA VF and to fill the gaps for more programming. I am hoping to learn, from surveying staff at my agency and three other BC Division branches: Shuswap Revelstoke, Kelowna and North + West Vancouver, to identify the needs of this population and to determine what is already working effectively to serve Older Adults and what additional programs the agency can consider developing to further support this population by identifying gaps in programming. The purpose of this research is to focus on the clients we serve and their needs, and to look at CMHA VF as a tool for how it can support its Older Adult clients with mental health/illnesses. My hope is that this project will allow other branches to identify gaps in programming for Older Adults as well, and build capacity for future programming.

Procedures involved in the Research

An online survey will be sent to staff at the three CMHA agencies and the Executive Director or Program Manager will assist in obtaining your CMHA work email address. As the purpose of this survey is to obtain insight from staff working with this population, it will not be distributed to management. A series of questions will determine the level of supports that are already offered to Older Adults and staff will be asked to offer their insights regarding where the gaps in programming are and what other programs can be implemented in the future better serve this population. The survey should take between 15-20 minutes and will be available for 10 days. By surveying staff at all participating branches will provide a detailed analysis of how they too may benefit from alternative programming.

Potential Benefits

Staff participation in the online survey will provide the opportunity for the researcher to identify the effectiveness of existing programs being offered to the Older Adult population and to identify what gaps are evident based on staff perception and experiences working with this population. The survey will ask staff to offer their knowledge and insight. This project will serve to benefit CMHA VF, its staff and the two other CMHA agencies as it will work for what is in their best interest for future programming.

Potential Harms, Risks or Discomforts to Participants

This research is very minimal risk and will not put any of the staff at risk or danger. There are no foreseeable risks involved in this study.

Confidentiality

Your personal information will remain confidential and anonymous. The survey will be voluntary and will not require staff to identify personal information. However, participants unfortunately will not be able to withdraw from the survey once they have submitted it as it is anonymous survey and therefore, individual surveys cannot be identified or withdrawn. Anything that you say or do in the study will not be shared with anyone else or published without your permission. Your privacy will be respected. All of the data will be kept confidential in a master data sheet along with the survey data that will be saved on a password protected USB and will be stored in a locked cabinet. Upon completion of the project, all material will be destroyed; i.e. all digital data stored on the USB and computers will be erased, shred all paper notes and analysis of data and erase the survey. The raw data will be destroyed August 2018 upon completion of the project.

Participation

Participation in the online survey is voluntary. However, participants unfortunately will not be able to withdraw from the online survey once they have submitted it as it is anonymous survey and therefore, individual surveys cannot be identified or withdrawn. Participants can refuse to answer some questions if they choose to, but participation is encouraged as it will only enrich the learning experience.

Study Results

The final report will be submitted to CMHA VF and CMHA BC Division branches: Shuswap Revelstoke, Kelowna and North + West Vancouver. The report will also be accessible for staff review. It will also be distributed to UFV for completion of the MSW.

Questions

CONTACT FOR INFORMATION ABOUT THE STUDY

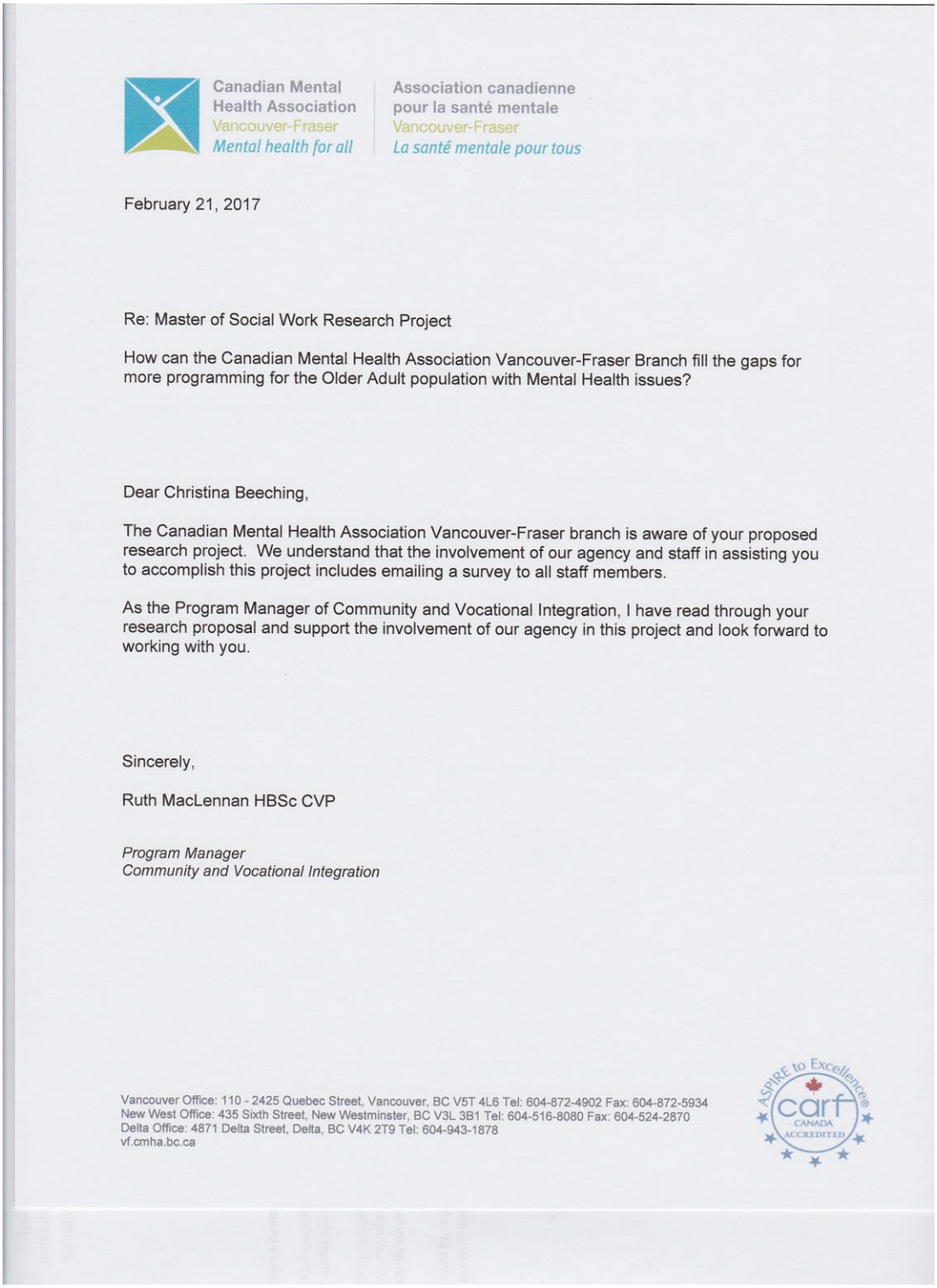
If you have any questions about the study you may contact Christina Beeching, the researcher at Christina.Beeching@student.ufv.ca or her Senior Supervisor, Dr. Darrel Fox at Darrell.Fox@ufv.ca.

CONTACT FOR CONCERNS

If you have any concerns regarding your rights or welfare as a participant in this research study, please contact the Ethics Officer at 604-557-4011 or Research.Ethics@ufv.ca. **The ethics of this research project have been reviewed and approved by the UFV Human Research Ethics Board.**

Appendix D

Letters of Support



Canadian Mental Health Association
Vancouver-Fraser
Mental health for all

Association canadienne pour la santé mentale
Vancouver-Fraser
La santé mentale pour tous

February 21, 2017

Re: Master of Social Work Research Project

How can the Canadian Mental Health Association Vancouver-Fraser Branch fill the gaps for more programming for the Older Adult population with Mental Health issues?

Dear Christina Beeching,

The Canadian Mental Health Association Vancouver-Fraser branch is aware of your proposed research project. We understand that the involvement of our agency and staff in assisting you to accomplish this project includes emailing a survey to all staff members.

As the Program Manager of Community and Vocational Integration, I have read through your research proposal and support the involvement of our agency in this project and look forward to working with you.

Sincerely,

Ruth MacLennan HBSc CVP

Program Manager
Community and Vocational Integration

Vancouver Office: 110 - 2425 Quebec Street, Vancouver, BC V5T 4L6 Tel: 604-872-4902 Fax: 604-872-5934
New West Office: 435 Sixth Street, New Westminster, BC V3L 3B1 Tel: 604-516-8080 Fax: 604-524-2870
Delta Office: 4871 Delta Street, Delta, BC V4K 2T9 Tel: 604-943-1878
vf.cmha.bc.ca

ASPIRE to Excellence® carf CANADA ACCREDITED

Canadian Mental Health Association
Mental health for all

Association canadienne pour la santé mentale
La santé mentale pour tous

March 6, 2017

Dear Christina Beeching,

Re: Master of Social Work Research Project at the University of the Fraser Valley

Research Question: How can the Canadian Mental Health Association Vancouver-Fraser Branch fill the gaps for more programming for the Older Adult population with Mental Health issues?]

The Canadian Mental Health Association Kelowna & District branch is aware of your proposed research project. We understand that the involvement of our agency and staff in assisting you to accomplish this project includes emailing a survey to all staff members.

As the Executive Director, I have read through your research proposal and support the involvement of our agency in this project and look forward to working with you.

Sincerely,

Shelagh Turner

Shelagh Turner MSc.
Executive Director

KELOWNA BRANCH | 504 Sutherland Kelowna BC V1Y 5X1 | T: 250.861.3644 | F: 250.763.4827 | www. cmhakelowna.org

Canadian Mental
Health Association
North and West Vancouver
Mental health for all

Re: Master of Social Work Research Project at the University of the Fraser Valley

Research Question: How can the Canadian Mental Health Association Vancouver-Fraser Branch fill the gaps for more programming for the Older Adult population with Mental Health issues?

Dear Christina Beeching,

The Canadian Mental Health Association, North and West Vancouver Branch, is aware of your proposed research project. We understand that the involvement of our agency and staff in assisting you to accomplish this project includes emailing a survey to all staff members.

As the Executive Director, I have read through your research proposal and support the involvement of our agency in this project and look forward to working with you.

Sincerely,

Sandra Severs

Sandra Severs
Executive Director

#300-1835 Lonsdale Avenue, North Vancouver, BC V7M 2J8

Canadian Mental Health Association
Shuswap-Revelstoke
Mental health for all

March 3, 2017

Re: Master of Social Work Research Project

How can the Canadian Mental Health Association Vancouver-Fraser Branch fill the gaps for more programming for the Older Adult population with Mental Health issues?

Dear Christina Beeching,

The Canadian Mental Health Association- Shuswap/Revelstoke branch is aware of your proposed research project. We understand that the involvement of our agency and staff in assisting you to accomplish this project includes emailing a survey to all staff members.

As the Executive Director, I have read through your research proposal and support the involvement of our agency in this project and look forward to working with you.

Sincerely,

Dawn Dunlop
Executive Director of CMHA and Shuswap Independent Living Association (SILA)

433 Hudson Ave. NE. Box 3275, Salmon Arm, BC V1E 4S1 • Ph: (250) 832-8477 • Fax: (250) 832-8410
info.sr@cmha.bc.ca • www.shuswap-revelstoke.cmha.bc.ca

Appendix E

Survey Questions

SAMPLE SURVEY – to be completed with FluidSurveys

1. Please identify your CMHA branch:
    a. Vancouver Fraser
    b. Kelowna
    c. Shuswap-Revelstoke
    d. North + West Vancouver

2. How many years have you been an employee at CMHA?
    a. Less than one year
    b. 1-2 years
    c. 3-4 years
    d. 5-6 years
    e. 7-8 years
    f. 9-10 years
    g. More than 10 years

3. a. Does your branch offer programming to Older Adults age 55+?
    No/Yes.

    b. If you answered Yes, please describe the nature of the program and the level of supports that are offered.

4. In your view, how well does the program respond to the initiating need?
    Very well
    Fairly well
    Poor
    Very poor
    Not sure/prefer not to answer

5. In your view, what is the biggest challenge facing the older adult population with mental health issues when accessing programming?

6. From the below list of possible programming opportunities, which do you feel is most necessary? Please rate from 1 – absolute need to 5 – least necessary.

    A. Living Life to the Full for Older Adults
    B. Employment Services for Older Adults
    C. Cognitive Behavioural Therapy groups for Older Adults
    D. Education and Outreach
    E. Recreational Programming for Older Adults

7. What existing program(s) is CMHA offering to older adults with mental illnesses? Please provide a brief explanation.

8. In your view, what types of future programs would you like to see implemented by CMHA that would better serve the older adult population? Please provide a brief explanation.

9. From your experience what type of education is needed for older adult clients? Please explain.

10. Should we consider being a hub for referrals for outside agencies wanting to refer older adult clients for programming?
    Yes
    No
    Not Sure

11. In your view, are the older adult population generally satisfied with what they gain from your program?
    Yes
    No
    Not Sure

12. a. In your view, do you think your agency would benefit from a pilot project for older adults in some capacity? Yes/No

    b. If yes, what should this look like? Please explain.